



Specific Excess Loss Notification of Potential Large Claim

High Cost DX High paid or pending IP stay of 5+ days Potential transplant Dialysis

Policyholder: _____ Policy Period: _____

Specific Deductible: \$ _____ Contract Basis: _____

Employee Name: _____ ID: _____ Date of Birth: _____

Hire Date: _____ Effective Date: _____ Termination Date (if applicable): _____

Claimant Name: _____ Date of Birth: _____ Relationship: _____

Effective Date: _____ Termination Date (if applicable): _____

COBRA Effective Date (if applicable): _____ Eligible for Medicare? Yes No

Claimant "Actively-at-Work" on Effective Date? Yes No

Is Claimant Covered by any other Group Insurance? Yes No

If Yes, Name of Carrier and Policyholder: _____

Total Claims **Reported** To Date: \$ _____ Total Claims **Paid** To Date: \$ _____

Amounts **Pending**: \$ _____ Estimate of Future / Total Liability: \$ _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Date of Onset: _____ On-Going Condition? Yes No

Current Physician: _____ Surgical Procedures: _____

Date(s) of Hospitalization: _____ Facility Name: _____

Is Facility In-Network? Yes No Contracted Discount: _____

Subrogation Involved? Yes No **If the diagnosis is related to an accident, please provide accident details.**

Case Management? Yes No CM Vendor: _____ **Please provide current CM report.**

Prognosis and Expected Treatment: _____

TPA _____ Contact Name _____

Telephone _____ Email _____

Signature _____ Date _____

Email to riskmgmt@truservices.com
TRU Services, A Liberty Mutual Company
152 Conant Street, 2nd Floor | Beverly, MA 01915
Fax: 978-564-0201 | Phone: 978-564-0200

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